ALAN WILSON

DENTISTRY

Imaging Referral Form

Referred by:

Clinician Name:_____

Practice Name: _____

Address: _____

_____

Postcode: _____

Telephone: _____

Email: _____

Patient Details:

Title: ____ **Forename:**_____

Surname:_____

Address:_____

_____

Postcode: _____

DOB: ___ /___ /_____ **Tel:** _____

Possibility of pregnancy: YES / NO

Payment: ☐ Patient to pay ☐ Account to referrer

Examination required:

☐ Cone Beam CT (£125) ☐ OPG (£75) ☐ Reporting (£75)

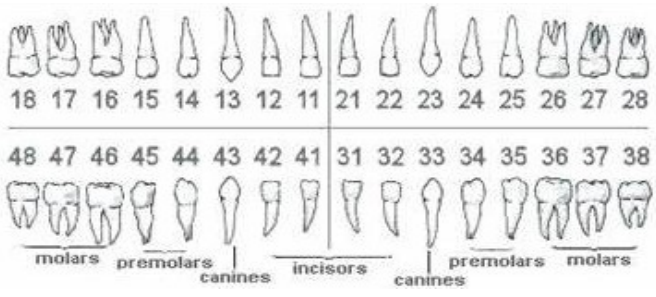
Purpose (mandatory):_____

Region of Interest: Full Arch - please specify: ☐ Upper ☐ Lower ☐ Both

For following options, please specify on diagram:

☐ Small Field of Vision

☐ Endo View



Delivery Options:

☐ CD ☐ Transfer via Cloud ☐ USB

Note: It is the referring practitioners' responsibility to ensure that all scans and radiographs are reviewed and reported appropriately in clinical records, in compliance with IR(ME)R regulations. The clinician at Alan Wilson Dentistry will take the scan with the lowest dose, smallest field of vision and best resolution, according to the area of interest and clinical indications, in line with IR(ME)R and ALARP. Age, anatomy and physical build of the patient are all dependent factors.